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BY

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MEMBER OF THE NEW YORK STATE MEDICAL ASSOCIATION,
ONONDAGA COUNTY MEDICAL SOCIETY,
CENTRAL NEW YORK MEDICAL ASSOCIATION,
SYRACUSE ACADEMY OF MEDICINE.

I wish to call your attention to the subject of adventitial or isolated neuritis, as illustrated by four cases under treatment by me, of which I shall give brief sketches:

Case I.—Jennie B., ten years of age, has had the simple diseases of childhood. Her family history is negative. She has sore throat frequently. After each attack she is lame in her left limb and has pain on extending the heel to the floor; she also limps. After an illness she walks first on the left toes. There is now no difference in the temperature of the two limbs; there is a slight atrophy in the affected limb, but no pain on moving the foot or knee joint, or on pounding on the bottom of the extended foot and limb, such as would occur in the hip if the disease were there. The knee-jerks are normal; there are no changes in sensation. The faradaic responses are good on the right side; the tibialis anticus responds with stronger current on the left side. The posterior group responds well.

The ætiology is a great aid to the diagnosis of this disease.

* Read before the Onondaga Medical Society, February, 1895.

Diagnosis.—Probably ataxic neuritis of diphtheritic origin, as a history was given of frequent sore throats.

In diphtheritic paralysis there is often a symmetrical neuritis, which was formerly thought to be always due to spinal-cord disease. But in this case we have healthy action of all but a single group of muscles.

These cases of diphtheritic neuritis are sometimes taken for poliomyelitis. But in poliomyelitis we have loss of the reflexes, marked atrophies, and the reactions of degeneration; in them the onset is also very acute and usually painless. In neuritis the course of the disease is different: we have pain, tenderness over the course of the inflamed nerves, decided paralysis in the distribution of the nerve, and other symptoms which will be enlarged upon in the cases which follow:

Case II.—Mr. W., aged fifty years. He was driving a fractious team of horses in winter, and wore a pair of tight kid gloves. The seam about the thumb pressed to a somewhat painful extent against the terminal filaments of the median and radial nerves. The thumb became intensely cold and painful, which caused him to think he had frozen it. The pain was only partially controlled by artificial heat, rubbing, and wrapping in flannels. Physicians were consulted, who treated him for a sprain, for rheumatism, and gout. Electricity was used—both galvanism and faradaism; also baths at Clifton were resorted to. When the patient was referred to me, the disease had continued for over three months. The patient was unable to dress himself or to use the hand in any way without extreme pain. If it became at all chilled, he also suffered. The skin presented a shining appearance and was extremely tender over the course of the nerves. Some of the same symptoms, only to a less degree, extended to the first finger and part of the second.

My diagnosis was neuritis from cold. I first ordered absolute rest of the arm, having it bound in flannel and carried

in a sling. Sometimes it is even necessary for a patient to remain in bed, to avoid the slightest movement, as the muscular contractions over these nerves are a source of constant irritation and pain. I gave this patient three grains of sodium salicylate and two grains of quinine, four times daily; also applied galvanism, applying the anode over the painful part of the nerve, giving daily sittings of about twenty minutes' duration. This patient made a complete recovery in about four months, and for two years has had no return.

Case III.—Miss G., while crossing the street, slipped on the ice and fell on the street-car track, striking the sciatic nerve. She was dazed and helpless, but in a few moments was able to move with assistance and was driven home. A physician was called, who prescribed liniments, which she used for a month with little benefit. When I called to see her I found the sciatic nerve swollen and extremely tender. The limb had wasted, and she was scarcely able to move, experiencing constant and extreme pain when attempting to do so, and walking in a manner resembling that of a person affected with tabes.

This patient was put to bed and artificial heat applied, as her condition seemed rather to suggest heat than cold, although Chapman's spinal ice bags are perhaps now used with greater benefit than hot applications in sciatic neuritis. Galvanism and internal medication were employed, as in Case II. This patient made a complete recovery in about four weeks. Last year she fell and struck the opposite limb in the same manner with the same symptomatology. After the course of treatment already mapped out had been employed with but little improvement, blisters were applied with some benefit. Deep-seated injections of from five to ten minims of a one-per-cent. solution of osmic acid were given once daily for three or four days. The pain had to be controlled by morphine, which many times only seemed to relieve when given hypodermically.

Deep cocaine injections are recommended, but they are only of temporary value. Nerve stretching I have not been

obliged to resort to, nor should I wish to except in a very extreme case, as paralysis sometimes follows such an operation.

Many cases of neuritis presenting ataxic walks and diminished knee-jerks with sluggish reflexes are mistaken for tabes. When the patients are cured they are reported as cases of tabes, when really they were only cases of neuritis. Fully ninety per cent. of cases of neuritis result from cold. The inflammation in a majority of these cases is in the sheath of the nerve, and a deposit is formed which presses on the nerve substance. In more severe cases the nerve tissue or substance is involved.

The symptoms of neuritis vary extremely according to its intensity, its extent, and the nerve that is affected. The chief symptoms are local. The most prominent is pain felt in the inflamed part of the nerve, and also often in the part to which it is distributed. Sometimes the pain involves the whole limb, and in severe cases it may be most intense, burning and boring, but rarely darting, in character: "a little devil boring away!" as one of my patients recently expressed it. The pain is increased by movement, by postures that involve tension or pressure of the nerve, and by whatever causes passive congestion of the limb, such as the act of coughing. Sometimes it seems to radiate into distant parts, and pain is often also felt in the corresponding region of the opposite limb. The sensitiveness of the affected region is increased, and even the bone may be tender, so that at first attention may not be directed to the nerve, but when this is pressed great pain is always produced. In slighter cases the pain is usually limited to the nerve and its distribution. If the nerve is accessible to direct examination it may sometimes be felt to be distinctly swollen at the affected part. Occasionally the skin over it is observed to be red. The muscles supplied by the nerve

become weak in various degree and tender, and present fibrillar twitchings. They are seldom powerless, but pain may prevent their contraction. They present the altered electrical reactions characteristic of nerve lesions. Sometimes eruptions occur; in some cases the epidermis thickens, as in ichthyosis; again, atrophies occur, as glossy skin. Constitutional disturbance subsides in the course of a few days. Frequently pain and other symptoms subside into a chronic stage and may continue as a secondary neuralgia. Alterations in the nutrition of the joints occur and adhesions form, limiting the movement of the limb. The inflammation is sometimes ascending in character, attacking the spine and continuing on to the nerves of the other side of the body. Also reflected pains are occasionally felt in the opposite side of the body when there are no evidences pointing toward neuritis. The following case illustrative of this is under treatment now:

A man of seventy years fell, over three months ago, striking on the right sciatic nerve. He developed a typical neuritis, with the symptoms already enumerated, although for some weeks he had been treated for a strain, with liniments, etc. The opposite limb began to develop reflex pains, with some weakness and tenderness, simulating neuritis very closely. Under treatment the symptoms subsided more rapidly than on the injured side. The patient is still under treatment and promises a fairly good recovery.

A slight acute neuritis may run its course in a few weeks and then subside. Much more commonly the affection persists in a chronic stage for many weeks and months. The diffuse pains that attend the onset may be mistaken for the pains that attend acute rheumatism, but in the course of a day or two the localization of the symptoms declares their nature.

Chronic neuritis is easily often mistaken for neuralgia;

but let us compare sciatic neuralgia and sciatic neuritis. In sciatic neuralgia we have some painful points along the nerve, intermittent pain, no loss of power, as a rule, except from pain, no atrophy, and no electrical changes; the reflexes are normal, and there is no loss of sensation; while in sciatic neuritis we have usually the entire nerve tender and painful; there is constant pain, decided paralysis in the distribution of the nerve, atrophy, electrical, sensory, objective, and subjective changes, and the reflexes are often diminished or lost. In both of these conditions, although the symptoms and clinical appearances differ, the treatment is quite similar. But one thing is absolutely imperative—viz., complete rest of the member, regardless of whatever medication is employed. If this precaution is not taken, disappointment is sure to follow any treatment.

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FRANK P. FOSTER, M.D.

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